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ABSTRACT

This report, issued by the National Institute on Drug Abuse, contains brief descriptions of program practices deemed innovative, unique, or facilitative, and potentially capable of adaptation by other State and local level program managers. The material was obtained through random contact with professionals around the country. The report attempts to provide information to managers about practices which may be useful in their own programs for and about former drug abusers. (Author/CC)

National Institute on Drug Abuse

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report series

NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION

SERIES 42, No. 1

MARCH 1979

The Office of Program Development and Analysis (OPDA) has the responsibility for planning and policy development within the National Institute on Drug Abuse (NIDA). As part of this function, OPDA issues a series of reports to the drug abuse field concerning legislation; trends in program development; Federal policies and regulations; analysis of critical issues; and program practices selected for their potential guidance to State and local programs, and for their informational value to readers. OPDA plans to issue similar reports from time to time, as part of a continuing effort to apprise State and local program staff of developments in the field. Readers interested in obtaining further information about the practices and procedures reviewed in this report may contact the appropriate agency. The material in this report was researched and written by PACE Management Associates, Washington, D.C., under Contract No. 271-77-1218.

A POTPOURRI OF PROGRAM PRACTICES

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POTPOURRI

This report contains brief descriptions of program practices which reviewers deemed innovative, unique or facilitative -- and potentially capable of adaptation by other State and local-level program managers. The material was obtained through random contact with professionals around the country. There is no inference that these 24 practices are the most unique or innovative. The report attempts to provide information that has not been published through regular Institute reports, or which has not been widely disseminated to the field. The objective is to apprise managers of practices which may be of use to them in their own programs. If there is sufficient interest in such reports, which are essentially a reference service, OPDA will consider additional reports with broader canvasses of program practices.

Reader reaction is therefore encouraged.

BUILDING A NEW COMMUNITY IMAGE FOR ADDICTS

The media-toughened image of the elderly cowering behind locked doors at night to protect themselves from society's delinquents is being challenged in New York City where senior citizens can be seen enjoying an afternoon visit to a museum, an evening at the opera, or downtown shopping trips -- accompanied by ex-addicts.

The ex-addicts are members of Senior Citizen Outreach Unit Teams (SCOUT), a community outreach program established by Project Return, a New York therapeutic community; the SCOUT Program is funded in part by the State Division of Substance Abuse Services.

The dual purpose of the SCOUT Program is to protect the elderly while simultaneously bridging the gulf of hostility between young and old.

Strongly supported by State and city government and a variety of community organizations, the SCOUT program provides transportation services (in its own vans) to the elderly to meet numerous needs, including trips to doctors and hospitals as well as recreational activities. The units will also deliver meals to shut-ins, using food provided by community service agencies.

The benefit to the program, sponsors say, is practical, vocational training for the ex-addict escorts, and an improved image for the ex-addict. The SCOUT program serves an area which includes 54,000 senior citizens.

The SCOUT program is part of a series of community outreach activites initiated by Project Return, which has also used all of its nine centers to provide Thanksgiving Day meals for the elderly, including shut-ins; supplied 200 volunteer workers to the City to help in last winter's snow removal operations; developed a work force of 50 addicts, using CETA funds, to clean the sidewalks in Time Square; cleaned up and replanted trees and shrubs in Union Square; distributed 462 pairs of new shoes (donated) to the city's elderly and homeless women; and organized teams to assist the city's derelicts. These community service projects are seen by the staff as not only improving the public image of the addict, but therapeutically are viewed as assisting the addict in developing a sense of purpose and community identification. The staff report that these activites (and the image) are important to their efforts to obtain full-time employment for their clients.

Principal supporters of Project Return, which includes special centers for women, youth, homosexuals, and school dropouts, include NIDA, New York State, and the Special Services for Children Division of the City Department of Social Services.

***For further information, contact Julio Martinez, Project Return Foundation, 444 Park Avenue, South New York 10006.*

LONGITUDINAL SCHOOL-BASED ANALYSIS OF PREVENTIVE EDUCATION

NIDA has funded a major, unique project to evaluate the impacts of school-based preventive education programs, through a grant with Pacific Institute for Research and Evaluation which (a) features affective education approaches aimed at student development as well as; (b) allows implementation of the project and its evaluation in eight schools; and (c) provides for longitudinal assessment of student development over periods of three years and longer.

The project is currently being implemented in the Napa Valley Unified School District in California. Essentially, the implementation phase of the three year project provides for inservice teacher training courses; school-based drug education courses for students; and service opportunities for students to teach and tutor other students in regular school subjects.

The three in-service strategies include: "Magic Circle" which is a program offering third grade teachers training in systematic skills, with the goals of increasing student cooperation, decreasing conflict and improving on-task learning; "Effective Classroom Management - Elementrary" which is a program offering fourth through sixth grade teachers training in building student involvement in the learning process, and in assisting students to learn self-management and interactive skills; and "Effective Classroom Management - Junior High" which is a similar course for junior high teachers, grades seven through nine.

The drug education course, which is offered to seventh and eighth grade students, attempts to put information about drugs and drug abuse into the context of human needs and normal human development, with the broad objectives of not only imparting greater knowledge about drugs but also decreasing intentions to use drugs, inculcating less-accepting attitudes towards drug use, and improving individual goal setting and decision-making skills. For example, the course includes discussion of theoretical perspectives for analyzing human needs, the dynamics of

peer pressure; effective means of resolving situations and coping with stress, the evolution of social attitudes and behaviors regarding drug use. The drug education component will be presented as part of a required course in physical education, health or social studies.

There are separate "service opportunity" programs for the elementary and junior high students. Fourth and sixth grade students can participate in peer and cross-age tutoring of students from kindergarten to age six, while junior high students can provide tutoring services to peers and tutoring or teaching services in grades four to six. The goals of this effort are to structure opportunities for improving social and intellectual competencies.

The research design incorporates two distinct approaches: (1) short-term assessments of the immediate and delayed effects of five prevention strategies -- the two classroom management projects, the drug education course, and the two service opportunity projects -- as delivered to separate groups of youngsters at different age levels; and (2) assessments of the cumulative effects of two sequential strategies delivered over two and three year periods -- the "Magic Circle" program for a cohort group of third grade students, and, the classroom management and drug education programs to a cohort of seventh grade students.

"Control groups for both sets of studies will be employed to include a same-year group, which does not receive the prevention program and a previous-year group, i.e. students one year older than the experimental group who also did not participate in the prevention program. Both control and prevention groups will be tested using a pre- and post-test design."

**For further information, contact: The NAPA Project, Pacific Institute for Research and Evaluation, 905 Jefferson St., Napa, California, 94558.*

TRAINING MANUAL FOR SERVICE PROVIDERS TO THE ELDERLY

Thee Door, a multi-disciplinary drug abuse and alcoholism treatment and prevention complex in Orlando, has developed a manual for training service providers who work with the elderly on problems of substance abuse.

The training program supported by the manual consists of three modules:

1. A portrait of the Elderly

   This course provides information about the physiology of the aging, the psychological dynamics of growing older, and the social issues related to the elderly -- with emphasis on the life stresses affecting the elderly which can affect the way drugs are managed, misused and abused.

2. Medication Misuse and Abuse Problems

   This course begins with an examination of the expectations and attitudes which older persons have about health and the role of medications. Trainees receive information about frequently misused prescription drugs and over-the-counter preparations, and on drug reactions and interactions that result from incorrect use. The objective is to identify drug mismanagement behaviors that lead to medication misuse and abuse. Also reviewed are the special needs of the elderly in receiving and taking drugs.

3. The Service Provider and Medication Management

   This training concentrates on the role of the service provider in assisting elderly clients in becoming better medication managers. Simulations of helping situations are provided to assist participants in practicing techniques for instructing and communicating with older clients about safe and effective medication use. Also included is information about the roles of other service providers who can assist the elderly when substance abuse problems have been identified, or, with the other needs of the elderly.

Each module is supported by instructions for trainers: resource materials; test materials; guidance on outcomes expected; and guidelines for training approaches and procedures that will insure maximum benefit from the material.

***For further information, contact Donald Feulner, Director, Thee Door, 1710 West Colonial Drive, Orlando, Florida 32804.*

EXECUTIVE REPORTS FOR SINGLE STATE AGENCIES & PROGRAMS

Through its management technical assistance program, NIDA has assisted the Illinois Dangerous Drugs Commission in developing and packaging a system of Executive Management Reports, which will serve the Commission as the basis for continuous policy analysis, planning, evaluation and monitoring.

The information components used to generate the reports include selected elements from the CODAP, NDATUS and DAWN data systems -- data which the package supplements through the collection of additional management-oriented data.

The information requirements for the Executive Management Reports were identified through a study of the kinds of information deemed to be needed by SSA managers for effective administration and evaluation.

Importantly, the package reflects the study finding that different data are needed, at different times, for various purposes, and the package therefore provides for monthly, quarterly, semi-annual and annual special reports which will be distributed to programs and agency staff. The study differentiated the information needs of each SSA unit as well as the information needs at local programs.

Data groups within the package include: (1) drug abuse problem data; (2) client characteristics data; (3) resource allocation and use information; (4) program and clinic performance data; and (5) SSA activities and progress information. The latter category, for example, organizes data pertaining to SSA objectives and centrally reports milestones achieved over reporting periods.

The package includes reporting formats, data generation instruments, and content materials for the reports.

***For further information, contact Thomas Kirkpatrick, Director, Illinois Dangerous Drug Commission, Suite 1500, 300 North State Street, Chicago, Illinois 60610.*

NEW CALIFORNIA PROGRAMS FOR PREGNANT ADDICTS

Pregnant addicts and their children, especially the addicted newborn, are the intended beneficiaries of the new grant programs and management procedures initiated by the California Single State Agency (Division of Substance Abuse, Department of Health).

The SSA has made formula grant funds available to San Francisco General Hospital for a demonstration research project, and neonatal and child development studies -- utilizing family, group and individual therapy.

Services to be provided by the hospital include comprehensive medical and psychological support for the pregnant addict, the passively addicted newborn, and for other children of these addicts. Women addicted to any drug, or any drug in combination with alcohol, are being treated.

The SSA has also awarded contracts to two residential programs to provide a family setting for substance abusing women and their children. These projects are intended as three-year demonstration/research projects, funded with formula grant funds.

The objectives of these demonstration projects are (1) to increase treatment opportunities for substance abusing women who have responsibilities for care of their children; (2) to analyze the characteristics of these women; (3) to provide residential treatment and preventive intervention for children of the drug abusing mothers; (4) to provide training and skills for the mothers; (5) to provide treatment for spouses and "significant others"; (6) to study the characteristics, development and needs of children of addicts in order to develop appropriate treatment responses; and (7) to delineate and enhance the parenting and life-coping skills of these women and their families.

The State agency, which has added data elements on pregnant addicts and their newborns to its management information system, also used Federal formula grant funds to conduct a study through Children's Hospital of San Francisco on passively addicted neonates. This study, which included evaluation of data over five years, examined the long-range impact of pre-natal exposure to addicting drugs on the infant's development. The report is available through the SSA.

***For further information, contact the Division of Substance Abuse, Dept. of Health, 915 Capitol Mall, Sacramento, California 95814.*

MODEL STATE AGREEMENT ON VOCATIONAL REHABILITATION SERVICES

A contract governing the exchange of services between the drug abuse and vocational rehabilitation fields, which could serve as a model for other Single State Agencies, has been negotiated between the Pennsylvania Governor's Council on Drug and Alcohol Abuse (SSA) and the State's Bureau of Vocational Rehabilitation.

The agreement is predicated on a new State policy, which reads, "Drug and alcohol abuse or dependence shall be regarded as a health problem, sickness, physical and mental illness, disease, disability, or similar term, for purposes of all legislation relating to health, welfare and rehabilitation programs, services, funds and other benefits."

The agreement stipulates that the Bureau will provide services to all drug and alcohol abusers referred by the Council who meet Federal and State vocational rehabilitation statutes and regulations, and

The services to be provided include: personal adjustment training; guidance, counseling, training and placement assistance; and general vocational rehabilitation services. The Bureau does not provide detoxification or other drug/alcohol treatment.

The Bureau has the sole right of determining elibibility.

The Council agreed to provide detoxification or other treatment prior to acceptance by the Bureau, and retains responsibility for further treatment, if needed, of any abusers referred to the Bureau for services.

While the Bureau is responsible for evaluation and monitoring of the programs, and the collection of appropriate fees, the agreement provides that rehabiliation services will be offered only in facilities licensed or approved by the Council.

The agreement also includes protections for confidentiality of patient records, medical and paramedical information made available to the Bureau.

***For further information, contact Gary Jensen, Director, Governor's Council on Drug and Alcohol Abuse, Riverside Office, Bldg. #1, 2101 North Front Street, Harrisburg, Pennsylvania 17110.*

CRITIQUE OF PRIMARY PREVENTION EVALUATIONS

A report is available from Pacific Institute for Research and Evaluation and the Prevention Branch at NIDA on PIRE's review and analysis of the evaluations conducted of 127 primary prevention programs.

Studies reviewed by PIRE, under its contract with NIDA, were limited to those evaluations which measured (a) program effects on drug use, (b) intentions to use drugs, and (c) attitudes toward drugs. Each study selected was analyzed and described on a base of 70 programming and research dimensions; the

analysis of these correlations was supported by a detailed summary of each study, which are not available in the formal report.

PIRE concluded that, taken together as a group, all 117 programs could be judged to be "slightly effective on the average" in influencing drug use behaviors and attitudes. But, PIRE reports that the most important findings were obtained from its special analysis of eight studies which it identifies as exemplary, i.e., studies which coupled the most intensive programming with the most rigorous evaluation protocols.

In this group, one of the eight evaluated a drug information-only program (and showed that program to be somewhat counter-productive) whereas the other seven studies assessed affective interventions, either alone or in combination with other prevention strategies.

PIRE concluded that these reviews of affective intervention programs suggest that the "new generation" of programs may help to prevent drug abuse problems -- the new generation being those programs which provide more than the single information unit.

The recommendations PIRE makes to NIDA may have value for other researchers. PIRE researchers believe the quality of impact data in primary prevention is still far from adequate for guiding policy formulation and program development -- the researchers saying that much of the available data in the studies reviewed came from studies which were poorly designed or conducted, i.e., they did not use control groups, or used only retrospective data, or used samples which were too small. Other criticisms were that the data were often inappropriately analyzed, the data were incompletely and unsystematically reported, and that the effort to evaluate prevention programs needs to be intensified.

Recommendations to NIDA included: (1) greater and more systematic evaluation of prevention programs oriented to minority groups; (2) regular updating and reanalysis of the impact literature; (3) better linkage in analyses between outcomes and actual program events; (4) development of detailed program descriptions which establish a context for the findings. (5) systematic program documentation through process evaluation as a predecessor to outcome evaluation; (6) greater use of multiple measurement techniques, not limited to questionnaires; (7) provision of more detail about drug abusing behaviors and patterns; (8) provision of complete demographic detail on clients served, (9) use of pre and post-tests; and (10) the use of equivalent comparison groups.

The report to NIDA includes, in addition to the narrative report and statistical findings, description of review instruments and procedures.

***For further information, contact Eric Schaps, the Pyramid Project, Pacific Institute for Research and Evaluation, Suite 201, 39 Quail Court, Walnut Creek, California 94596.*

ADVICE ON ACHIEVING SELF-SUFFICIENCY IN FUNDING

The Division of Addiction Services in the Indiana Department of Mental Health is making available a limited number of copies of the proceedings of its conference on self-sufficiency in funding for drug abuse and alcoholism treatment programs.

The focus of the conference was on the identification and accessing of non-Federal funds from other public as well as private resources -- with an emphasis upon obtaining non-government funding.

The conference papers included in the proceedings are case-history presentations explaining how treatment and prevention programs have developed a wide variety of entrepreneurial efforts which produce independent incomes for programs.

For example, in addition to the expected discussions of accessing third-party payments, CETA funds, other Federal and State agency funds, and foundation grants, there are discussions about treatment program ventures into such income-producing activities as restaurants, gasoline stations, mail-order marketing, thrift shops, publishing, operating speakers' bureaus, etc., and the methods by which programs have obtained bank loans and other commercial financing for such ventures. Emphasis is also given to methods for contracting-out the services of the substance abuse programs to receive/assist clients referred by other community service providers.

The advice from the speakers also includes guidance on organizing program managment for marketing ventures and on how to market the program and its services -- as well as on marketing its entrepreneurial activities.

***For further information, contact Ron Custance, Division of Addiction Services, Indiana Department of Mental Health, 5 Indiana Square, Indianapolis 46204.*

PREVENTION MANUAL FOR RURAL COMMUNITIES

A manual entitled, "A Comprehensive County-Wide Drug Prevention System for Rural Communities," has been developed by the California SSA. The manual resulted from a 1977 conference sponsored by the SSA; the conference was designed to assess the unique problems of small counties including their limited resources, geographical isolation, small tax base, scarcity of experienced professionals.

The conference provided workshops on criminal justice prevention strategies, education strategies, media work, the role of the medical profession in prevention, and the development of coping skills.

The manual includes guidance on: (1) basic prevention concepts; (2) goals for rural community-based prevention programs; (3) training prevention staff; (4) coordination and leadership of a county-wide system; (5) coordination of prevention efforts in the schools; (6) prevention program process; (7) needs assessment procedures; (8) identifying services and development of communication networks; (9) lobbying and advocacy; and (10) establishing a kick-off campaign. The manual was designed by SSA staff to serve as a model for rural counties wishing to establish prevention programs in their communities.

***For further information, contact the Division of Substance Abuse, Dept. of Health, 915 Capitol Mall, Sacramento, California 95814.*

FLORIDA EXPANDS ALPHA PREVENTION CENTERS PROGRAM

The State of Florida proposes in its current budget to expand from three to nine the number of Alpha Centers -- which are school-based prevention-education programs targeted toward 8 to 12 year olds who display maladaptive behaviors.

The Alpha concept, developed by Thee Door of Orlando, which currently operates three such centers, focuses on underlying problems of adolescent alcohol and drug abuse, such as poor home environment, low academic achievement, insufficient self-control, poor motivation, and low self-concept.

When a school has been targeted for inclusion in the Alpha program, teachers in grades three through six are asked to identify children who are displaying disruptive behavior, or who are failing to perform adequately or who are experiencing family difficulties. About one to three children per classroom qualify. After consultation with teachers, guidance counselors, school psychologists, and principals, the Alpha team obtains parental

permission for these students to participate -- along with a commitment to attend weekly parent education classes and/or family counseling.

Alpha works with cohorts of twenty students, who, after pre-testing for social behavior and academic skills, engage in an eleven-week program. The students are transported to the Alpha Center three days a week, where the focus is on behavioral change through group and individual counseling and other affective education activities -- combined with teaching in such basics as individualized math and reading, arts and crafts, and physical education.

The students are disciplined by involving them in deciding the consequences for their inappropriate behaviors.

Although the students return to their normal classes the other two days, the Alpha center staff work with the teachers and students one day a week in the school, and the other day of the week is devoted to inservice training of teachers. The in-service training component trains teachers in different classroom management techniques and interpersonal communications skills; topics covered include transactional analysis, reality therapy, behavior management, positive reinforcement, and communication skills.

Through a combination of activities in the family home and in formal parenting classes, the Alpha staff not only assist parents through counseling, but, where poor home lives are resulting from parental problems in subsistence, the Alpha staff assist the parent in overcoming such basic problems as providing food, clothing and shelter.

Recent evaluation reports released by Thee Door show that the Alpha program is effective in identifying and assisting high risk populations; using the Jessness Inventory, staffers found that the students as a group more closely resembled delinquents than non-delinquents, with 17% scoring well into the delinquent range.

Using the Burks' Behavior Rating Scale, the Alpha staff found that, after participation, the students showed significant gain on nine of twenty scales, with indications of improving academics, impulse control, anger control, social conformity, and sense of identity, accompanied by reduced aggressiveness, resistance and suffering. Seventy-seven percent of parents surveyed reported improved behavior at home.

***For further information, contact G. Hale Pringle, Thee Door, 1710 West Colonial Drive, Orlando, Florida 32804*

SUBSTANCE ABUSE MEDICAL EDUCATION PROGRAMS

The Indiana SSA (Division of Addiction Services, Department of Menatl Health) has awarded an 18-month grant to the Department of Psychiatry, University of Indiana School of Medicine, to establish a substance abuse medical education program -- which includes actual exposure to substance abuse clients.

The major goals of the project are:

1. To provide medical students with an adequate teaching exposure to problems of the substance abuser so they may acquire the appropriate knowledge, skills and attitudes to manage these patients effectively;

2. To provide focus for teaching residents in psychiatry and other primary care specialties concerning patients with substance abuse problems;

3. To provide focus on patients with substance abuse problems in the School of Medicine;

4. To provide the impetus for improved services to substance abuse patients within the medical campus; and

5. To promote and encourage relevant clinical research in the area of substance abuse.

During the first six months of the project, substance abuse-related content has been introduced into the first and second-year Medical School curricula. Planning sessions have been conducted with various departments of the School and hospital administration in order to establish a program for clinical rotation of third-year students, involving exposure to substance abuse clients.

Three first-year students will participate in a ten-week clerkship program during which they will have extensive and intensive exposure to substance abuse clinical services.

***For further information, contact Ron Custance, Division of Addiction Services, Department of Mental Health, 5 Indiana Square, Indianapolis, Indiana 46204.*

MARYLAND DEVELOPS CITY BLOCK GRANT

A major change has taken place in 1978; the SSA contracts with counties, but, because the City of Baltimore is not part of

Baltimore County's administrative net, the SSA dealt directly with nearly two dozen programs in the city. The SSA and its counterparts in alcoholism and mental health have proposed an agreement with the City in which the State would provide a block grant to the City Hospital for all drug abuse, alcoholism, and mental health services, and the city would subcontract with existing agencies and manage the contracts through the Hospital.

** *For additional information, contact Richard Hamilton, Director, Drug Abuse Administration, O'Connor Building 201 West Preston Street, Baltimore, Maryland 21201.*

COSTS ALLOWANCES FOR DRUG ABUSE SERVICES

The New Jersey Division of Narcotics and Drug Abuse (SSA) has been investigating the implications of a funding system based upon assigning different costs for various units of services. As part of its analysis of the potential impact of such a system (tentatively titled Fee for Unit Service), the SSA has developed time-study data on the costs associated with all of the various services provided within a drug treatment program.

Note that all dollar expressions are in terms of a unit of service, not an hour or day of service. For example, the taking of a medical history is estimated to consume 30 minutes, and to cost $5.76 for the services of a nurse. However, the development of a treatment plan by a physician is estimated to require only ten minutes, but cost $14.05. Counselling sessions are based upon hourly units, but vary in cost according to the staff utilized.

The hypothesis being considered by the New Jersy SSA is that funding on a unit of service base, at negotiated costs per unit, could be a more effective and efficient method of funding programs.

**For further information, contact Richard Russo, Director, Division of Narcotics and Drug Abuse, P.O. Box 1540, Trenton, New Jersey 08608.*

BILINGUAL AND BICULTURAL SERVICES FOR PARENTS AND CHILDREN

The Child Development Center of Santa Clara County has been funded by the California Division of Substance Abuse (SSA) to design and implement a bilingual and bicultural child care center -- serving parents and surrogate parents who have experienced addiction and/or substance abuse problems, and their children.

Programmatic services or components, provided to approximately 30 children and 30 parents, include (1) providing children with a learning environment relative to their cultural background; (2) providing a supportive atmosphere; (3) providing experience to develop social competence; and (4) providing health services, parent education and training; family social services assistance; and field trips and activities.

The program is funded by the State from Federal formula grant funds.

***For further information, contact the Division of Substance Abuse, Dept. of Health, 915 Capitol Mall, Sacramento, California 95814.*

NEW JERSEY'S PROBLEM ORIENTED TREATMENT SYSTEM

The New Jersey Division of Narcotics and Drug Abuse (SSA) has completed development of its Problem Oriented Treatment System -- a new case management method designed to help the counselor (1) complete a more comprehensive assessment of client needs upon entering treatment; (2) define the client's problems relating to drug abuse; (3) formulate individualized client treatment plans; (4) organize the delivery of treatment services; and (5) conduct regular reviews of client progress.

Essentially, the SSA has designed a system that facilitates the counselor receiving more and better refined information about the client at admission, during treatment, and at discharge -- with special emphasis upon the client's changing needs during the process.

As a corollary effort, the SSA has redesigned its management information system to reflect the usage of these new data forms and instruments -- which are compatible with the CODAP forms and procedures used by NIDA, as well as the data instruments used by FDA and DEA.

The New Jersey SSA says that traditional, source-oriented systems typically develop on an unstructured basis, with each of the various providers (primary counselor, nurse, physician, vocational specialist, etc.) recording data about the client according to that provider's special point of view.

The SSA cites these consequences of an unstructured approach:

- a broad, total view of the client is difficult to obtain because data are fragmented by provider specialty or function; as a result treatment may be directed only at fragments of the client instead of the total client;

- o there are structured rules setting what data should be collected at minimum for each client, which often results in insufficient knowledge about the client, and, possibly, some problems which are left unidentified;
- o there are no rules for defining problems and ensuring that the problems are followed through to resolution;
- o communication among providers is difficult because notes are spread to different parts of the client record; and
- o quality of care review and training are hampered because every client case is documented differently.

The elements of the Problem-Oriented Treatment Systems (POTS) are:

1. The Data Base
2. The Health Questionnaire
3. The Physical Examination Record
4. The Treatment Plan
5. Progress Notes
6. Discharge Summary

From the cornerstone assessment -- the Data Base -- problems are identified and grouped into five categories: (1) health/drug use; (2) legal; (3) employment/vocational; (4) educational; and (5) psychosocial.

A wealth of data on social behavior and behavioral attitudes is generated by the extensive Data Base instrument. When counselors convert this data into problem sets, they are required to develop treatment plans, short and long-range, which identify precisely (a) the statement of the problem; (b) the statement of the treatment goal or objective; and (c) the intervention strategy that is to be used.

In turn, counselors must file progress notes, carefully reporting subjective and objective findings -- these findings become the basis for the subsequent treatment plan review, which must be conducted periodically, and, can result in modifications to the treatment plan.

The organization of this detail permits the SSA to code the forms, thus expanding significantly the range of information available for eventual program analysis, monitoring of client trends, research reports, etc.

***For further information, contact Richard Russo, Director, Division of Narcotics and Drug Abuse, P.O. Box 1540, Trenton, New Jersey 08608.*

THE PLURALISTIC WORLD OF SINGLE STATE AGENCIES

While there is a tendency in the drug abuse field to think of Single State Agencies as independent entities, a perspective perhaps rooted in their role as managers of funds and resources, the fact is that these agencies have become elements in inter-dependent networks of service providers -- reflecting both the need to provide a range of special services to drug abuse clients in different situations, and the role of drug abuse within larger, statewide health service systems.

A review of 1978 SSA plans reveals that, without exception, but, in varying degrees, every Single State Agency reports a number of inter-agency affiliations. There tends to be extensive involvement in many States between the SSA and the State agencies serving on its advisory council, or on inter-agency councils, in providing services to drug abusers -- increasingly, these services are being provided through inter-agency agreements.

The diversity of such inter-agency coordination apparently results from the expansion of primary prevention programming; efforts to provide ancillary and supporting services; the increased attention being given to women, youth and minorities; the special efforts to divert the criminal offender/abuser into treatment; the implementation of P.L. 93-641 (health planning); the quest for third party reimbursements; the merger of alcoholism and drug abuse agencies; the pursuit of new recommendations from the Office for Drug Abuse Policy; and, the adoption in several States of a behavioral health approach to drug abuse.

Although there is evident similarity in the identities of these ancillary service agencies with whom SSAs interact, the form and degree of interaction vary from State to State.

Frequently, the interaction occurs on the legally-required SSA Advisory Council. For example, the Massachusetts Drug Abuse Advisory Council includes: The Attorney General; the Secretary of Human Services; the Secretary of Manpower Affairs; Public Safety; Administration and Financing; Educational Affairs; Criminal Justice Commission; Parole Board; Corrections; Probation; Public Health; Mental Health; Public Safety; Public Welfare; Education; Rehabilitation; Office for Children; Comprehensive Health Planning Agency; Division of Employment Security; and the Division of Drug Rehabilitation. In addition to these State agencies, the Massachusetts Council includes representatives from the Judiciary, drug treatment programs, the City of Boston, VA programs, minority groups, professional societies; regional citizen boards, and the drug rehabilitation advisory board.

However, some States have more traditional lay advisory councils and use State-level inter-agency boards or councils to effect their needed inter-service arrangements. For example, the Office of Substance Abuse Services in Michigan serves on an inter-departmental substance abuse committee with Pharmacy; Social Services; Education; State Police; Corrections; Vocational Rehabilitation Service; Public Health; Civil Service; Mental Health; the Governor's Office; and the Employment Security Commission.

In some, the SSA has independent membership on key boards and councils, whose concerns are not limited to drug abuse. For example, the New York Division of Drug Abuse Services is a member of the State Health Planning Commission, a member of the Crime Control Planning Board, and a member of the Inter-Agency Juvenile Justice Task Force.

In sharp contrast to the 1972 concept of an SSA having direct operational responsibility for all drug abuse-related services, some States have diversified and decentralized key functions. For example, in Virginia, the Division of Substance Abuse draws upon a wide range of Mental Health Department services; the co-equal Division of Planning, Evaluation and Training provides technical support for the development of State plans, is the liaison for Title XX funding, conducts research in issues related to substance aubse, provides substance abuse information and clearinghouse materials, develops evaluation systems, supports training, and develops and implements substance abuse licensing criteria and standards.

The trend is toward single agencies having dual responsibilities for alcoholism and drug abuse, but there are States where the level of interaction is high, even when the functions are not merged. For example, in Illinois, the Dangerous Drugs Commission has established working relationships between its regional coordinators and alcoholism coordinators, and the two agencies are sharing reviews of planning documents as well as discussing common efforts in prevention, training, worker certification, and services to overlapping client populations.

The complexity of establishing a single new service for drug abusers is reflected in these interfaces. For example, in New Jersey, the SSA, using Federal guidelines and with assistance from the Rehabilitation Services Administration, worked with the State Department of Health, the Criminal Justice Planning Agency, and the State's Division of Vocational Rehabilitation to establish a Vocational Adjustment Center under the authority of the New Jersey Regional Drug Abuse Agency, which has now become a certified Class A rehabilitation agency.

The complexity is even more sharply delineated by examples of the degree of interaction needed to provide the total package of services which SSAs are almost routinely expected to provide directly or secure through other agencies. Pennsylvania provides a good example of why all of those other agencies are members of advisory boards and councils -- and an example of the increasing importance of formal inter-agency agreements:

- The Department of Public Welfare provides Medicaid funds directly to programs -- but the Legislature transferred to the SSA (from DPW) the powers of regulation, supervision and licensing for treatment programs.

- The SSA is one of three members of the committee to develop policy for drug law enforcement.

- The SSA serves on the Child Care Alternatives Committee which is developing a pilot program which will serve as a model for counties as they develop coordinated programs between child welfare and drug/alcohol services.

- The SSA provides training in counseling to probation and parole officers, and the Probation and Parole agency purchases services from community treatment programs.

- The SSA worked with the Bureau of Corrections to establish detoxification facilities in county corrections institutions, using SSA treatment standards.

Given the multiplicity of needs and ancillary resource programs, these inter-agency agreements can be extensive -- with a number of agencies for a single purpose, or, with a single agency for a number of purposes. For example, the New Jersey SSA works with twenty-nine different agencies and organizations in primary prevention planning. On the other hand, the South Carolina SSA's involvement with just one other State agency (it has many such inter-agency arrangements) demonstrates the diversity of bi-lateral interactions. The SSA provides training to Social Service caseworkers, while Social Services contracts with the SSA to provide community based treatment, and the SSA negotiates with Social Services on Title XX.

Increasingly, as the SSAs develop new programs and respond to major issues, they are working with and even helping sponsor a variety of special interest groups and committees. For example, the New Jersey SSA regularly meets with the Patient Advisory Committee; the Hispanic Advisory Committee; the Women's Awareness Group; the Elderly Task Force; the Association of Private Treatment Programs; and the State Clinic Supervisors' Committee.

NEW YORK: DE-EMPHASIS OF STATE-OPERATED SERVICES

The 1978 plan discloses that the Governor and Legislature directed the SSA to: continue the de-emphasis of direct State services; reduce state residential services; reduce administrative staff; and concentrate services in community based programs.

In keeping with these mandates, residential facilities have been reduced to three direct-operation rehabilitation centers (once there were more than two dozen); these three centers will have a capacity of 300 patients who need a highly structured setting (there were nearly 10,000 at the height of programming under the Rockefeller civil commitment program); State-directed outpatient slots have been reduced to 1,800 and State methadone maintenance programs have been phased out and clients placed in local programs.

Thus, the biggest of the State-operated treatment systems has virtually come to an end; although some States do still provide direct services, there was nothing on the magnitude of the old Narcotic Addiction and Control Commission whose budget once exceeded the combined drug abuse treatment budgets of the Federal government and 49 other States. Staff has been reduced from a high of 3,800 in 1975 to below 1,000.

As the plan says, "ODAS is an agency which today differs markedly from what it was a year ago. New management and internal reorganization have brought about an agency that is a fraction of its former size, one that emphasizes local programming and views the drug abuse problem as a health and social problem rather than primarily a criminal justice problem. Gone is the emphasis on State-operated treatment centers and open competition with local agencies. The three remaining centers now provide care only to those individuals who cannot benefit from local programs. The agency's annual budget has gone from a high of $150 million to about half that amount, with most of the money going to fund over 400 local programs and clinics."

PRESCRIPTION DRUG MISUSE

The Committee on Prescription Drug Misuse, a special purpose group funded by Narcotic and Drug Research, Inc. of New York City, is preparing final recommendations to the State of New York for a multi-faceted, five-tier program attacking the problem. (Narcotic and Drug Research, Inc. is controlled by and acts as a funding agent for the New York Single State Agency.)

The Committee is preparing recommendations in five areas: (1) medical education; (2) public information; (3) programs for the elderly; (4) programs for industry; and (5) treatment strategies and services.

Specific action items now being evaluated by the Committee include: medical school and continuing education programs for physicians; publications on prescribing practices to be placed in medical journals; updating New York State's physician desk reference which is used by private practitioners and medical emergency room staffs; creation of a professional speakers' bureau; a major consumer education program which would instruct the public about consumption practices, the dangers of specific drugs, shelf-life characteristics, effects of various combinations of drugs, etc.; public information programs which advertise the availability of services to meet specific drug emergencies; special education and assistance programs for the elderly, including efforts to assist the elderly in reading and understanding labels, and understanding the potential effects of excessive dosages; special programs aimed at securing the sponsorship of colleges of pharmacy in developing gerontological dosages; industry programs designed to assist employees in identifying and obtaining referrals for services; and developing a model program specifically designed to assist the kinds of clients who abuse prescription drugs.

Committee staff say major focus will be given to training needs, to preventive education strategies, and encouraging the health community to go beyond detoxification to more comprehensive support services for such clients.

The Committee itself is a special undertaking, i.e., it represents an effort by the State to coordinate a variety of public and private interests in a common focus on a single problem. The Committee's 30 members include doctors, nurses, media, pharmacists, program specialists, psychologists, labor, banking, drug manufacturers, and public interest groups such as Pills Anonymous.

** *For further information, contact Hildy Simmons, Committee on Prescription Drug Misuse, Division of Drug Abuse Services, Executive Park South, Albany, New York 12203.*

DRUG ABUSE PLANNING BY HSA'S

The Indiana Single State Agency, Division of Addiction Services, has contracted with the three Health Systems Agencies in the State to produce the formal sub-State plans which comprise the major elements of the annual State plan submitted to NIDA.

Indiana decentralized its Statewide planning operation several years ago, assigning 14 regional planners the responsibility for developing local and regional plans.

Now, the State has been divided into 13 subareas within three health systems areas. The HSAs utilize substate addictions planning committees to obtain city, county and regional plan

inputs, develop health status and health system objectives, and to detail recommended action plans.

Payment to the HSAs is made by the Division, based upon individually negotiated contract terms.

> ***For further information, contact John Jones, Assistant Commissioner, Division of Addiction Services, Department of Mental Health, 5 Indianapolis Square, Indianapolis, Indiana 46204.*

METHADONE TO ABSTINENCE TO AFTER-CARE

New York State's Division of Drug Abuse Services is facilitating program compliance with its request that methadone maintained clients be given the option of continuing maintenance or being detoxified by allowing methadone programs to continue the client on the program rolls -- after detoxification -- to receive continuing counseling and other program services.

Agency staff say the Division is supporting a concept of client flexibility, wherein State contracts with methadone programs will specify certain numbers of clients who can be kept on the program rolls, for reimbursement purposes, at zero dosages -- provided the client receives basic services after detoxification at least once per month.

Currently, about 300 out of some 30,000 methadone maintained clients have been detoxified and engaged in the after-care program.

Program personnel in New York City who were contacted for this report say there is genuine need, given the poor performance of many clients after having been detoxified and discharged, for a true after-care component. Agency staff say the program is too new to measure any improvements in recidivism. Although the new concept is gaining visibility, agency staff say the State does not advocate total maintenance or total detoxification, but, supports a policy of client choice. New SSA regulations, incorporating the after-care procedures, are being prepared for publication.

> ***For further information, contact Ken Keeley, Division of Drug Abuse Services, State of New York, Executive Park South, Albany, New York 12203.*

MAXIMIZING THIRD PARTY PAYMENTS

The Pennsylvania Governor's Council on Drug and Alcohol Abuse (SSA) reports achievement of a major fiscal objective: increasing the rate of third-party reimbursements to at least a third of program costs while reducing absolute dependence on categorical Federal aid.

Published reports from the SSA for fiscal year 1977-78 show that third-party payments now comprise 36.54% of all program funding, compared to 36.48% for the State and 7.24% for NIDA and NIAAA. Medical Assistance now provides $19.2 million or 27.87% of the total State budget of $68.9 million for drug and alcohol abuse programming at the community level, with SRS reimbursements and other third-party type payments accounting for 1.81% and 6.86% respectively.

This high level of non-categorical funding has allowed the State to extend the impact of its dollars, the reimbursements being used to complement SSA dollars to expand treatment services.

While SSA officials believe one key to their success in capturing these third-party dollars is the political influence of the agency, they lay great stress on the strength of the inter-agency relationships they have established with reimbursement agencies.

For example, the SSA negotiated with the Department of Public Welfare to include all drug/alcohol outpatient clinics, free-standing or hospital affiliated, as well as for inpatient hospital services. DPW agreed to accept the SSA's approval of projects in lieu of DPW licensure; approved projects are placed on a special Medical Assistance list, and bill DPW directly, according to approved rate schedules.

The State undertakes a variety of activities to assist community programs in qualifying for and being paid by reimbursement programs. For example, the SSA is developing an interim licensing procedure to facilitate recognition by Blue Cross agencies; using SSA funds where needed to meet costs of approvals by the Joint Commission for Accreditation of Hospitals, and training SSA staff in project approval procedures that meet JCAH standards; and, the State, through its county authorities, is easing the cash flow problems of community programs by allowing them to bill and be paid by the county in advance of actual reimbursement from third-party agencies.

The SSA has a series of publications, memoranda, etc. which provide additional detail on their extensive third-party reimbursement program.

***For further information, contact Gary Jensen, Director, Governor's Council on Drug and Alcohol Abuse, 2101 North Front Street, Harrisburg, Pennsylvania 17110.*

MANAGEMENT PROCEDURES FOR SINGLE STATE AGENCIES

A system procedures manual, which details the myriad functions to be performed by Single State Agency staff and assigns timelined responsibilities for each function, has been published by the Alcohol and Drug Abuse Division (SSA) of the Colorado Department of Health.

The manual, more than a hundred pages in length, organizes agency functions generically: program development; planning and evaluation; fiscal; management information; licensure and prevention; and, director's office (administration through management by objective).

The manual identifies each of a multitude of tasks; explains task purposes; identifies persons responsible within the agency for each task; outlines task procedures; and identifies all of the inputs and outputs associated with each task -- including documents to be generated. To insure agency-wide understanding of procedures, all report forms have been standardized and copies of each such instrument are included in the manual -- which serves as a self-instruction manual for staff members.

The emphasis throught the manual is on management-by-objective, supported by standardized procedures and reporting. Typical of the system management procedures developed by the Division is the approach to providing technical assistance to grant and contract agencies. Among the several intended benefits of the manual used to monitor technical assistance is that the agency will now have a continously updated report on (1) program needs; (2) types of needs by number and category; (3) assistance required to meet those needs; (4) levels of effort of assistance provided; (5) results of on-going assistance; and (6) unmet needs.

The document control procedures for technical assistance (including report formats) include: (a) a monthly TA report summary; (b) a TA request which identifies need, the kind of assistance proposed, and resources required, as well as man-day projections; (c) a monthly TA backlog summary, with staff projections of efforts needed to resolve the backlog; (d) a TA workplan report which details the action to be taken on-site, including specific tasks and timelines by task, and reports on accomplishments and remaining problems; (e) a TA request log which allows supervisors to track requests, workplan preparations, performance and report preparation; and (f) a standardized TA visit letter format which advises the program of the assistance to be rendered.

Implicit in the control procedures are commitments by the SSA to (1) insure that all program requests for assistance are brought to the attention of appropriate supervisors, analyzed, and responded to with appropriate resources, and (2) insure that the

agency is continously aware of the kinds of needs, particularly the continuing unmet needs of service programs.

***For further information about the systems procedures manual or the inherent technical assistance manual, contact Jeffrey Kusher, Director, Division of Alcohol and Drug Abuse, Colorado Department of Health, 1101 Bellaire, Denver, Colorado 80220.*

PERSPECTIVES OF FEE FOR SERVICE SYSTEMS

The Pennsylvania Governor's Council on Drug and Alcohol Abuse (SSA) recently conducted a retreat for Council members to discuss the implications of fee-for-service payment systems.

Among the documents prepared for the retreat were position papers prepared by (1) a Council member and (2) two county officials.

Stanley M. Nelson, the Lancaster County Mental Health/Mental Retardation Administrator, concluded: "A purchase of service approach offers a great potential for developing a program of services shaped by the needs of the client population.

"A purchase of service technique can succeed, however, only if (a) a technique of client management and review can systematically match an array of service activities to individual client objectives and goals; and (b) all available community service resources can be conceptualized systematically as providing an array of service activities paralleling the system of client management."

W.H. Torrence, Jr., Executive Director of the Bucks County Drug and Alcohol Commission, offering a rationale for a Statewide fee-for-service system, said that an annual needs assessment is critical to such a system, and that the data derived from the assessment should be utilized to arrive at decisions as to ceiling amounts to be allocated within broad categories, e.g., residential, outpatient, prevention, treatment, crisis intervention, etc. Torrence agreed that a comprehensive case management system is equally essential -- and suggested that the case management service should have no organizational ties to community service providers, so as to maintain objectivity.

Declaring that a unit costing procedure would be the first step in establishing such a system, Torrence concluded, "The attractiveness from an administrative standpoint is obvious. Such a system would enable the State funding agency, via the county administrative unit, to reimburse participating programs following the provision of services...Rather than being concerned with utilization rates or with the level or number of services provided within a particular program, programs would be required to provide services or suffer the fiscal dilemma of reduced reimbursement...The most pronounced effects include the potential

reduction in the administrative costs of service delivery through the unit costing procedure, an increased ability on the part of the county and state to fund treatment by virtue of the increased competition, and a more effective service delivery system."

Council Member Ruth DeBois offered a contrast of fee-for-service with current block and grant funding systems: "Under a program funding system...there is little financial incentive for clinics to see a maximum number of clients or to operate at maximum efficiency. Under fee-for-service, these responsibilities rest with the programs. Greater fiscal responsiveness is an obvious benefit of fee-for-service.

"Under program funding, individual therapists may lose sight of the limited monies available for their service. Efforts to reduce the number of clients who fail to meet their scheduled appointments may not be vigorous; efforts to increase the hours spent in direct contact with clients have no apparent reward. Under fee-for-service, the therapist can only bill for direct service and the time is limited to a specific unit.

"One other advantage of a fee-for-service system is the avoidance of duplication of services, and the utilization of outside resources with the county or local community. Instead of a program trying to provide all components of service, it must know and use what is available."

However, Ms. DuBois would not eliminate all program funding, saying that new programs must begin with such categorical funding. She would allow a program one year to become fully licensed and then convert to a fee-for-service basis; she also recommended the State adopt a flexible program that would allow certain options for continued program funding to meet special situations.

Copies of papers presented at the retreat are available from the Governor's Council.

The conclusion of these presenters was an unequivocal opinion that fee-for-service was definitely the funding system of the future for both drug abuse and alcoholism programming.

***For further information on the retreat and Pennsylvania's consideration of fee-for-service systems, contact Peter Pennington, Deputy Director, Governor's Council on Drug and Alcohol Abuse, 2101 North Front Street, Harrisburg, Pennsylvania 17110.*

AFFIRMATIVE ACTION PLANS

A comprehensive affirmative action plan, based upon months of research of Federal and State laws and regulations, has been published by the Alcohol and Drug Abuse Division of the Colorado Department of Health.

The plan sets forth Division policy on employment of agency staff, a declaration supported by (a) a summary of the provisions of Federal and State law and regulation; (b) specific assignments of responsibility for compliance monitoring by an Affirmative Action Committee, as well as by the affirmative action officer, the equal employment opportunity officer, and all division supervisors; (c) establishment of timetables for declared goals, including specific hirings of minority group persons; and (d) procedures for monitoring, reporting and evaluation.

The accompanying policy notices state that the SSA Advisory Council will also pursue the affirmative action policy with regard to its membership.

***For further information, contact Jeffrey Kushner, Director, Alcohol and Drug Abuse Division, Colorado Department of Health, 1101 Bellaire, Denver, Colorado 80220.*

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The National Clearinghouse for Drug Abuse Information, operated by the National Institute on Drug Abuse on behalf of the Federal agencies engaged in drug abuse education programs, is the focal point for Federal information on drug abuse. The Clearinghouse distributes publications and refers specialized and technical inquiries to Federal, State, local, and private information resources. Inquiries should be directed to the National Clearinghouse for Drug Abuse Information, P.O. Box 1908, Rockville, Maryland 20850.